

North Portland Wellness Center – MVA New Patient Info

Welcome to the North Portland Wellness Center. Please print clearly and answer all questions as completely as possible.

Full Name: _____ / _____ / _____ / _____
(Legal Last Name) (Legal First Name) (Middle) (Preferred First Name)

Date of Birth: ___/___/___ Age: _____ Sex/Gender: Female Male Transgendered (circle: FtM/MtF) Other: _____

Address: _____ / _____ / _____ / _____
(Street/PO box) (City) (State) (Zip Code)

Phone #: (_____) _____ (_____) _____ (_____) _____
(Home) (Work) (Cell/Other)

As a courtesy, we can notify you of upcoming appointments. Please check your preference:

Phone Text message Cell Phone carrier: _____ Email

Email address: _____

May we send you occasional coupons, discounts, event notices, and/or newsletters via email? Y N

Occupation/Employer: _____ Full-time Part-time Student Retired Unemployed

Are you: Single Married Partnered Divorced Widowed Partner's Name: _____

Emergency Contact: _____ Phone #: (_____) _____ Relationship: _____

How did you hear about our clinic? Please check ALL that apply, and let us know whom to thank:

- | | | |
|--|--|---|
| <input type="checkbox"/> Live/Work in Neighborhood | <input type="checkbox"/> Citysearch | <input type="checkbox"/> Doctor/Clinic: _____ |
| <input type="checkbox"/> Insurance Company | <input type="checkbox"/> Gay & Lesbian Yellow Pages | <input type="checkbox"/> Personal Referral: _____ |
| <input type="checkbox"/> ReDirect Guide | <input type="checkbox"/> Yelp | <input type="checkbox"/> Event: _____ |
| <input type="checkbox"/> Internet Search | <input type="checkbox"/> Natural Awakenings Magazine | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Portland Monthly | <input type="checkbox"/> Supportland | |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Twitter | |
| <input type="checkbox"/> MetroParent | | |

Motor Vehicle Accident Claim Information

Insurance Carrier: _____ Claim #: _____ Claim Submitted: Y N

Date of Injury: ___/___/___ State where accident occurred: _____ Adjuster's Name: _____

Address for Claims: _____ Carrier or Adjuster's Phone #: _____

Attorney's Name: _____ Phone #: _____

Primary Insurance

Insurance Carrier: _____ Plan Name: _____

ID/Subscriber #: _____ Group #: _____

Primary on Policy? Y N, answer following for Primary Insured: Legal Name: _____ DOB: ___/___/___

Insured's ID #: _____ Patient's Relationship to Insured: _____

By signing below, I verify that the above information is correct and true to the best of my knowledge. I hereby authorize North Portland Wellness Center to submit claims, along with any necessary chart notes, to my insurance carrier(s) or their intermediaries for all services rendered by North Portland Wellness Center and direct them to issue payment directly to North Portland Wellness Center. I understand I am responsible for all charges not covered by my insurance company.

Patient Signature (or Guardian if Patient is a minor)

Date

Informed Consent to Treatment

The purpose of this form is to present risks and benefits of the therapies offered at North Portland Wellness Center. While the chances of experiencing most of these complications listed below are small, it is the practice of this clinic to inform patients about them. This form must be signed before treatment is rendered. Please discuss any questions/concerns you may have with our staff or your practitioner.

ACUPUNCTURE

Acupuncture involves using very thin needles and/or pressure to stimulate special points on the body that affect different organ systems. Our acupuncturists are gentle and effective and combine traditional Chinese bodywork and other techniques to aid in energy flow. Side effects may include bruising, minor bleeding, discomfort, and on the rare occasion, fainting. More commonly, relaxation and pain relief are experienced. Your acupuncturist may use acupressure and Chinese bodywork, which stimulates or sedates the points by hand.

CHIROPRACTIC CARE/MANIPULATION

Chiropractic examinations and therapeutic procedures (including chiropractic manipulation, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. However, there are occasions when a procedure intended to help may have complications. These complications may include but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications, such as strokes and disc herniations, are extremely rare.

MASSAGE THERAPY

The purpose of massage/soft tissue therapy is to decrease pain, tension and tenderness, while increasing blood and lymph flow. Your health concern may be caused by poor body mechanics and/or repetitive stress, in which case, exercises or stretches may be indicated. Massage may cause initial soreness, bruising or lightheadedness, but usually pain relief, increased mobility, and relaxation are experienced.

STEAM/HEAT/HYDROTHERAPY

Steam, heat, and hydrotherapy are helpful for many conditions, but may not be appropriate for everyone. With steam therapy, there is risk of scalding or serious burns if the patient comes into close proximity of the steam head. Patients should not touch or attempt to move/hold any body part over the steam head, as it releases very hot water. Patients with diabetes, heart disease, multiple sclerosis, abnormally high or low blood pressure, impaired temperature sensation, or who are pregnant or have any other recurrent or persistent medical condition should always consult their primary care physician before utilizing a steam shower or other body treatment. Steam therapy and body treatments can cause people to become tired. Elderly people and young children are more susceptible to exhaustion caused by heat and should avoid lengthy full-body treatments.

SUPPLEMENTS, HERBALS, HOMEOPATHICS, ETC.

Your practitioner may suggest a product to aid your healing. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly, allergic reaction. If biomechanical support is needed, back braces, cervical pillows, cervical traction, and/or orthotics may be suggested for your particular health issue.

IMAGING, REFERRALS

Further lab work (x-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested.

Please inform your practitioner of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy at any time during your care. If you would like additional information on side effects/complications that could result from treatment or product use, please discuss these with your practitioner.

I have read and understand the above statements concerning treatment side effects and risks, and I also understand that there is no guarantee for a specific cure or result. I understand both my rights and responsibilities in this practitioner/patient relationship.

I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

Patient Name (Please Print)

Relationship to Patient (if not self)

Patient Signature (or Guardian if Patient is a minor)

Date

Motor Vehicle Accident Intake

Patient Name: _____ DOB: _____

DESCRIPTION OF ACCIDENT

Date of injury: _____

Describe your vehicle involved in this accident (type, make, model):

State the location/address where the accident took place:

Describe your experience of the accident:

Driver, which of your hands were on the steering wheel: Right Left Both None

Passenger, were you sitting in: Front Right Rear Left Rear

Were you wearing a seat belt: Yes No

Approximate speed of your vehicle at the time of accident: _____ MPH Approximate speed of other vehicle: _____ MPH

Did your vehicle strike another vehicle: Yes No, the other vehicle struck your vehicle

COLLISION DETAILS

What was the angle of impact of the first collision: Front Back Right Left

If applicable, what was the angle of impact of the second collision: Front Back Right Left

Did you brace for impact, and how: Yes, with my hands Yes, with my feet No

Which way were you facing at the time of impact: Straight ahead Right Left

Did your body strike any of the following at the time of impact:

Steering Wheel Dashboard Right-side Door Right-side Window Other: _____

Windshield Roof Left-side Door Left-side Window No, I didn't strike anything

Did the seat back bend or break: Yes No

Did your airbag deploy: Yes No

SYMPTOMS FROM ACCIDENT

Did you get bleeding cuts or bruises? No

If yes, what bleeding cuts did you receive? _____

If yes, what bruises did you receive? _____

Please describe how you felt. *PLEASE BE SPECIFIC.*

Immediately after the accident: _____

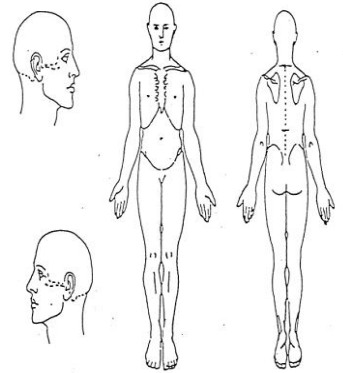
Later that Day Night _____

The next day(s) _____

Patient Name: _____ DOB: _____

Check the symptoms apparent since the accident:

- Headache
- Neck pain/stiffness
- Midback pain
- Low back pain
- Eyes sensitive to light
- Pain behind eyes
- Blurred vision
- Dizziness
- Fainting
- Ringing/buzzing ears
- Loss of balance
- Loss of smell
- Loss of taste
- Nausea
- Loss of memory
- Fatigue
- Tension
- Shortness of breath
- Irritability
- Depression
- Sleeping problems
- Numbness in toes
- Numbness in fingers
- Cold hands
- Cold feet
- Diarrhea
- Constipation
- Chest pain
- Nervousness
- Cold sweats
- Anxious
- other _____
- Shoulder pain
- Elbow pain
- Wrist/hand pain
- Hip pain
- Knee pain
- Ankle/Foot pain
- Jaw pain



WORK STATUS HISTORY

Occupation: _____ Employer: _____

Have you missed time from work? Yes No

If yes, full time off work _____

If yes, part time off work _____

Been unable to work since accident

FIRST DOCTOR/HOSPITAL/CLINIC SEEN

Did you go to seek medical help immediate/soon after the accident? Yes No

If yes, how did you get there? Someone else drove me Drove own car Ambulance Police

Doctor/Hospital/Clinic Seen: _____

Were you examined? Yes No Were X-rays taken? Yes No

Were you treated? Yes No or prescribed medication? Name of medication(s): _____

If yes, what treatment was given to you? _____

What benefits did you receive from the treatment? _____

Date of last treatment: _____

Are you currently seeking treatment? Yes No

If yes, Provider name: _____ Specialty: _____

I hereby authorize NPWC to contact my provider(s) as necessary for my continued care and treatment.

Patient Signature (or Guardian if Patient is a minor)

Date

Patient Name: _____ DOB: _____

PRIOR SIMILAR SYMPTOMS

Did you have any physical complaints **just before the accident**? Yes No

If yes, what physical symptoms did you have? _____

PRIOR to this accident, have you **EVER** had symptoms similar to what you're experiencing now? Yes No

If yes, please explain (briefly include past falls, injuries, accidents, operations, etc.): _____

ACTIVITIES OF DAILY LIVING

Do you notice any activities of your home daily routines that are different now than from before the accident? Yes No

If yes, list them as:

Those activities that you are now unable to do are (be specific): _____

Those activities that are now painful to do are (be specific): _____

Those activities that are now difficult to do are (be specific): _____

What activities or position aggravate your symptom(s)/condition/pain?

- Bending Sitting Driving Lifting Getting up/down Sneezing Twisting Walking
- Coughing Standing Lying down Straining Typing Other _____

What activities or positions relieve your symptom(s)/condition/pain?

- Nothing Stretching Lying Down Rest Exercise Massage Ice Acupuncture
- Chiropractic Heat Standing Sitting Medication: _____ Other _____

CURRENT MEDICATIONS

Do you take or use?

- Laxatives Pain relievers Antacids Oral Contraceptives
- Cortisone Hormones Sleep Aids Blood Pressure medication
- Tranquilizers Thyroid medication Antidepressants/anti-anxiety Cholesterol medication
- Coumadin

If you take or use the following, please list (use back of page, if necessary):

Prescription Medications:

- 1. _____ 3. _____
- 2. _____ 4. _____

Vitamins/Supplements/Herbals/Homeopathics

- 1. _____ 3. _____
- 2. _____ 4. _____

HOSPITALIZATION, SURGERIES, & ACCIDENTS

What other hospitalizations, surgeries or accidents have you had (use back of page, if necessary)?

_____ year: _____ year: _____

Please list dates of x-rays, CAT scans, MRIs or any other study done within the past 5 years: _____

Patient Name: _____ DOB: _____

HEALTH HISTORY

Date of most recent full physical exam: _____ Results: _____

If you have ever had a listed symptom in the past, please check that symptom in the ***Past*** column. If you are presently troubled by a particular symptom, check that symptom in the ***Present*** column.

- | Past | Present |
|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Nervousness, irritability, anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> Mental tension |
| <input type="checkbox"/> | <input type="checkbox"/> Moodiness, depression, melancholy |
| <input type="checkbox"/> | <input type="checkbox"/> Tired, weak, lack of energy |
| <input type="checkbox"/> | <input type="checkbox"/> Sleeplessness, sleep too much |
| <input type="checkbox"/> | <input type="checkbox"/> Frequent colds or other illness |
| <input type="checkbox"/> | <input type="checkbox"/> Don't sweat enough |
| <input type="checkbox"/> | <input type="checkbox"/> Sweats too much |
| <input type="checkbox"/> | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> | <input type="checkbox"/> Swelling/stiffness of Joints |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting, visual disturbance, nausea |
| <input type="checkbox"/> | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> Headache |
| <input type="checkbox"/> | <input type="checkbox"/> Muscular in-coordination |
| <input type="checkbox"/> | <input type="checkbox"/> Tinnitus (ear noises) |
| <input type="checkbox"/> | <input type="checkbox"/> Rapid heartbeat |
| <input type="checkbox"/> | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> | <input type="checkbox"/> Abnormal weight <input type="checkbox"/> gain <input type="checkbox"/> loss |
| <input type="checkbox"/> | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> | <input type="checkbox"/> General fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> Loss of bladder control |
| <input type="checkbox"/> | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> Constipation/irregular bowel habits |
| <input type="checkbox"/> | <input type="checkbox"/> Heartburn/indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/eczema/rash |

- | Past | Present |
|--------------------------|---|
| Male specific | |
| <input type="checkbox"/> | <input type="checkbox"/> Prostate exam, including blood test |
| <input type="checkbox"/> | <input type="checkbox"/> Problems with prostate |
| Female specific | |
| <input type="checkbox"/> | <input type="checkbox"/> Irregular Periods |
| <input type="checkbox"/> | <input type="checkbox"/> Periods have ceased |
| <input type="checkbox"/> | <input type="checkbox"/> Profuse Menstrual Flow |
| <input type="checkbox"/> | <input type="checkbox"/> Vaginal Discharge |
| <input type="checkbox"/> | <input type="checkbox"/> PMS |
| <input type="checkbox"/> | <input type="checkbox"/> Use Birth Control: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> Painful Menses |
| <input type="checkbox"/> | <input type="checkbox"/> Gynecological or Abdominal Surgeries |
| <input type="checkbox"/> | <input type="checkbox"/> Breast Soreness /Lumps |
| <input type="checkbox"/> | <input type="checkbox"/> Pregnancy
How many weeks? _____ |

Your current weight: _____ lbs. / Height: _____ feet _____ inches

Habits/Lifestyle

How do you rate your stress level on a scale of 1-10?
0 = lowest, 10 = highest: _____

Do you consume:

- | | |
|--|-----------------------|
| <input type="checkbox"/> Cigarettes or tobacco | _____ packs a day |
| <input type="checkbox"/> Coffee/tea/sodas | _____ cups a day |
| <input type="checkbox"/> Sugar | _____ times a day |
| <input type="checkbox"/> Processed/fast foods | _____ times a day |
| <input type="checkbox"/> Alcohol | _____ drinks per week |
| <input type="checkbox"/> Marijuana/other drugs | _____ times per week |

TYPICAL FOOD INTAKE

- Breakfast: _____
 Lunch: _____
 Dinner: _____
 Snacks: _____
 Drinks: _____

How much water do you drink a day? _____

Do you exercise regularly? What and how often? _____

Please list anything that you may be allergic to: _____

Patient Name: _____ DOB: _____

FAMILY HISTORY

Please check here if you are adopted or otherwise unaware of your family's medical history

Please Check All that Apply	Self	Mother	Father	Grandpar.	Siblings	Children	Spouse
Cancer							
Heart Disease/Angina/Heart Attack							
Digestive Problems							
Respiratory Problems							
Urinary Tract Problems							
Diabetes							
Hypoglycemia							
Thyroid Disease							
Gall Bladder Problems							
Low/High Blood Pressure							
Anemia							
Migraines							
Stroke							
Epilepsy							
Tuberculosis							
Allergies							
Asthma							
Arthritis/Rheumatoid Arthritis							
Blood Disorder							
Kidney Disease							
Lupus							
Mental Health Issues/Concerns							
Birth Defects							
Substance Dependency							
Age at death, if applicable	NA						
Cause of death	NA						
Other							

Signature _____

Date _____

Motor Vehicle Accident Treatment Policies

Thank you for choosing to seek treatment at The North Portland Wellness Center. As navigation of a car accident, insurance companies, attorneys and treatment policies can sometimes be complex, we've pulled together this list of items to make sure you have a clear understanding of your prescribed care and responsibilities.

Please take the time to read, initial each section, and sign our *Treatment Policies* to acknowledge that you understand them. If you have any questions regarding these agreements, please discuss them with the NPWC staff. We've found that a clear understanding of our policies and procedures helps to create a strong foundation of confidence and communication toward your path of healing and recovery.

_____ Your insurance policy is a contract between you and your insurance company. Therefore, it is your responsibility to be fully aware of your PIP (Personal Injury Protection) coverage & deductibles and to track how close you are to reaching your treatment maximum. This is especially important if you are treating at multiple clinics as we cannot track services that another clinic may have billed on your behalf. In Oregon you may have \$15,000 in PIP coverage, but there are many factors that affect payment limits. For the most up-to-date information about your coverage, we advise that you keep in touch with your adjustor and/or attorney.

_____ Your insurance provider may pay only a portion of the charges for your treatment. You are responsible to pay for any balance on your account. Any account that carries a balance beyond 30 days, will incur a monthly billing administration fee of \$5-\$10. Considerably delinquent accounts are subject to collection procedures. Any collection fees will become the patient's responsibility.

_____ Due to the potential complexities of dealing with insurance claims, we highly recommend that you seek legal counsel immediately after any motor vehicle accident. Most attorneys work on contingency and may offer a free consultation so you can fully understand your rights and how an attorney may be able to help you.

_____ At the North Portland Wellness Center we typically recommend a treatment plan that includes a combination of Acupuncture, Chiropractic and Massage to aid in your recovery from injuries sustained in a motor vehicle accident. We find that this combination of therapies works synergistically to speed your healing process and offer the best chance of complete recovery.

_____ Patients are responsible for following the referral, prescription, or treatment plan prescribed by their physician or provider. Most PIP policies require a referral for massage. If you are treating with a Chiropractor at the NPWC, they will be responsible for managing your massage referral but it is your responsibility to follow it as prescribed. Insurance companies may not pay for services when the referral is not followed.

_____ Patients are responsible for informing the clinic and their practitioner about any scheduled Independent Medical Exams (IMEs) as future treatment payment may be dependent upon the outcome. Many insurance companies will suspend payment on claims until the IME is completed and some will deny all coverage/payment after the IME is performed, so this is very important.

_____ Your practitioner may suggest and/or prescribe supplements, herbs or therapeutic products to aid in your treatment and some of these may not be covered by your insurance policy. You are responsible for any products not covered by your policy at the billed rate. We are unable to give refunds or credits on any supplements or herbal products, opened or unopened.

_____ Should you need to pay for products, fees or services, we accept payment forms in cash, Visa, MasterCard and Discover. We also accept local (in-state) checks with photo ID that lists the address provided on the Patient Info form. Please note, there is a **\$30 fee** for each returned check.

_____ As a courtesy to our patients, we ask that you silence your cell phone and other personal devices when entering the center and step outside to make or take any phone calls. We also ask that you use a soft voice while in the building, so as not to disturb other patients receiving treatment.

_____ There is a **\$50.00 fee** for each no-show and/or appointment cancellation with less than 24 hours notice. If you need to cancel or reschedule an appointment, please be sure to notify us at least 24 hours in advance to avoid being charged. This fee cannot be billed to your insurance claim and is fully your responsibility.

As a patient of North Portland Wellness Center, I acknowledge and agree to the above statements and understand that a part or all of my care may not be covered by my insurance. I acknowledge and agree to be financially responsible for my treatment.

Patient Name (Please Print)

Relationship to Patient (if not self)

Patient Signature (or Guardian if Patient is a minor)

Date

Privacy Practices

As our patient, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which we secure your information confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

In-Office Security

Notes that are taken during appointments are kept in your chart and are secured in our clinic at all times. If patient charts are in public areas, they are kept private with the names covered. Access to this office is limited to practitioners, employees, preceptors, and supervised guests.

Public Interaction

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health only in the office setting to protect your privacy and to ensure that important information is kept in your chart.

Consultations

North Portland Wellness Center practitioners may consult with each other, other healthcare practitioners and/or clinical/laboratory specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, fax, or email are confidential and names are not used unless necessary and consent is provided from you either verbally or in writing.

Records Released

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. Copies of released records are sent by mail or fax and are accompanied by a confidential patient information cover sheet, if faxed. This clinic is not able to email patient records at this time.

Definitions and Penalties to Comply

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) Is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse in the normal course of business, and 2) Related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual. This information may reside in any medium: paper, disc, fax, email, and/or digital voice message.

Voicemail Policy

Practitioners and staff will not leave detailed information when leaving a voicemail message unless authorized by the patient to do so, so as to protect confidentiality.

I have read and understand my right to privacy, as stated above, and agree to have the practitioners/staff of North Portland Wellness Center maintain my records confidentially in accordance with the law. I agree to inform the practitioners and/or staff of North Portland Wellness Center if I need any special arrangements pertaining to this issue.

North Portland Wellness Center has the right to update the terms described in this Privacy Practices notice. I may obtain a revised Privacy Practices notice by calling the office and requesting a revised copy be sent in the mail, or by asking for one at my next appointment.

Patient Name (Please Print)

Relationship to Patient (if not self)

Patient Signature (or Guardian if Patient is a minor)

Date

FOR OFFICE USE ONLY: WE ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WERE UNABLE TO DO SO AS DOCUMENTED BELOW:

Date: _____ Reason: _____ Staff Initials: _____